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ORIGINAL ARTICLES

THE OPERATIVE TREATMENT OF FRACTURES*

CHARLES L. SCUDDER, M.D.
BOSTON, MASS.

Great attention is being focussed today on a study of fracture problems in many large centres throughout this country. There is manifest also a very general interest in fractures in the profession at large. At this time I am attempting to state briefly certain facts bearing on the development of the operative treatment of fractures and to express a personal opinion as to the applicability of the operative treatment to special conditions.

When is the operative treatment of fractures of the long bones justifiable?

My reply briefly is: Whenever the operative treatment is needed or required to secure the best result following a given fracture.

It is unfortunate that today large groups of dependable and comparable case histories are not available for study and comparison.

I can personally recall watching with awe thirty-five years ago, Dr. J. Collins Warren, the attending surgeon in my ward 28 in the Massachusetts General Hospital, score or slash a closed fracture of both bones of the leg for impending gangrene, due to tension from hemorrhage following damage to important vessels below the knee. The posterior and anterior tibial pulses were absent, the toes and foot were blue and cool. By these incisions Warren rendered a closed or simple fracture compound or open! The outcome of this logical and bold step was watched with apprehension. The man recovered with a sound leg.

Compare this episode with the certainty, assurance, and boldness accompanying a premeditated incision to the bone today. The change in attitude toward such a procedure is almost unbelievable.

*Read before the Rhode Island Medical Society at the Annual Meeting, June 3, 1926.

I can recall the arguments had at about that same time by C. B. Porter and J. C. Warren, master surgeons, over the use of absorbable vs. non-absorbable suture material in fracture of the patella. At that time, fracture of the patella was the only closed recent fracture treated occasionally by operation. I remember with what glee Dr. Warren heard of a refracture of a healed patella sutured by Dr. Porter with silver wire! Of course, the refracture was thought to have been due to the use of the non-absorbable wire, and Dr. Warren considered at that time that he was more than justified in his contention for absorbable suture material!

Those were stirring times indeed! ! Personal feeling ran high. We youngsters shared in the excitement and of course took sides with our chiefs. We discussed the problems at issue. Those were days of military conformity in surgery. The climate of surgical opinion was foggy. The balanced and enlightened surgical mind of today was in the making.

What a contrast between then and now!
Timidity has given place to boldness,
Emergency measures to premeditated operations.

The operative treatment of fractures has come to its present important place as a recognized part of general surgery gradually, progressively, and comparatively recently.

All real advance in the art of surgery is and must be individualistic.

The sixteenth century saw the rise of modern science. Copernicus and Vesalius typify the scientific emphasis on direct observation.

The quiet growth and dissemination of science has colored our ways of thinking.

William James wrote, "I have to forge every sentence in the teeth of irreducible and stubborn facts." Surgeons are now more absorbed than ever in stubborn facts and in the weaving of general principles. This balance of mind, this interest in fact and in generalization, has become part of the tradition which infects cultivated thought.

This tradition of a balanced surgical mind is being transmitted as a widespread, fortunate inheritance from generation to generation by our university medical schools and by teaching-hospitals.

Following the recognition in the sixteenth century of the importance of observation and the necessity of recording these observations, there came in the nineteenth century the influence of anaesthesia, of antisepsis, of asepsis, and of the roentgen ray. Agencies each of fundamental basic importance.

In the nineteenth and twentieth centuries were taken the remarkable strides toward the perfection of general surgery, noticeably of neurological surgery, the surgery of the thoracic organs, abdominal surgery, including the surgery of the gastrointestinal, genitourinary, and pelvic organs.

Diseases of all these various organs often killed the individual. The pathology of many of these diseases became generally known. Consequently the best minds of the time took cognizance of relief through appropriate surgery. "As is our pathology so is our practice." Osler.

It was thought that fracture of the skeleton never killed—they only crippled, deformed, and incapacitated. When, however, it came to be recognized that fractures killed (and you recall that the mortality rate in compound fractures was from 85 to 90 per cent! Attention was focused on the dire and lethal condition of an infected fracture. Through the work of Pasteur and Lister soon the mortality from compound fracture was greatly diminished. Today an ordinary civil compound fracture has a low mortality rate.

"As is our pathology so is our practice." Osler.

Fractures continue to be treated unsatisfactorily. In large numbers the long lines of disabled and crippled keep limping on. A moving picture could be constructed of enormous value and startling in its portrayal of fracture disabilities, and that, too, of cases treated today. A hideous commentary and reflection! !

The industrial awakening of the nineteenth and twentieth centuries, the great war, the appearance of complicated machinery, and the universal use of automobiles has been a tremendous stimulus to the treatment of fractures.

Today the involved limb is regarded properly as a part of a complicated and co-ordinated, intelligent mechanism. The limb is interrelated with other parts of the body. Likewise, the muscular, vascular, and neurological structures are influenced by changes in the limb. Temporary disuse affects these structures. The damage to the limb by fracture may be intimately connected with metabolic and other processes as well. The long bone is a part of complicated mechanism.

The industrial importance of the individual with a fracture relates him to the economic and social structure in a very definite manner.

Today a more precise conception of the nature of bone obtains. Bone is no longer to be regarded as a dry, inert, stable, terminal form of matter. Bone is a living, unstable, changing tissue, sensitive to all extraneous influences and events. Walt's conception of the skeleton as a repository of calcium from which available calcium is always to be had as needed, is suggestive. The conception of the automatic balance of bone calcium being maintained as carefully as is the sugar balance of the body certainly is a fascinating theory.

The reaction of bone tissue to fracture, to trauma, is recognized as a complicated series of events called the process of repair. These processes and many of the influencing factors are being intensively studied. The final word is not yet.

Whether the healing of bone is a physical or chemical process or a combination of the two, is as yet undetermined.

What the exact function and origin of the cells concerned in the reparative processes are, is unsettled.

For our purposes in this discussion, it may be affirmed without fear of contradiction that an appreciation of these conceptions of repair, even though incomplete, has had and is having a profound influence for a sane treatment of fractures.

"As is our pathology so is our practice." Osler.

It is a stimulating thought and I believe a logical one that the serious discussion today of the operative treatment of fractures coincides with the technical perfection of pathological surgery. This is not a mere coincidence. General surgery has been improving, developing up to and for this event. It was impossible for the treatment of fractures adequately to develop until this perfection in pathological surgery had been attained. Lane's attempt at the promulgation of the operative treatment was unfortunate. Such ill-timed popularization was bound to be followed by terri-

ble results and disasters such as have been seen in this country since 1909. Lives, limbs, the power to earn a livelihood were sacrificed in the popular attempts to improve fracture surgery by indiscriminate operating.

The non-operative methods *were* inadequate, as Mr. Lane pointed out. The logical direction for improvement at that time lay in a better non-operative treatment. Those times were not prepared for the operative treatment to be generally adopted.

Someone has said that an uneducated man has two mental pigeonholes, one called absolute truth and the other called absolute falsehood. Every idea that comes to such a man has to be put into one pigeonhole or the other. Whereas, an educated man and especially a surgeon has a long row of mental pigeonholes. That at one end of the row is labelled "Absolute Truth." It is always empty. That at the other end is labelled "Absolute Falsehood," and it, too, is always empty. Every idea, every experiment, every observation, every recorded experience is put into the intervening pigeonholes, and as occasion requires and confirmation is forthcoming, he moves them closer to one end or the other. In this way by a succession of approximations, he approaches absolute truth, the methed best suited to the always variable conditions at hand. Surgical theories and practice are only approximately ideal but fortunately are approaching a better and still better standard of excellence.

The recognition of the functional importance of crippling due to fracture, an idea developed by Lane, has been growing for some years. The general industrial awakening to an exact economic value of this loss of function from fracture is a development of recent times.

That the limb is a part of an intelligent mechanism, that the will is involved in every fracture, that it influences the recovery of function: The signficance of these facts is too little appreciated.

That bone is intimately involved with other tissues; that a fracture of bone is closely and complexly related to all parts of the body in ways as yet not entirely understood: these are comparatively modern facts and are bound to have their influence on the treatment of fractures.

That bone is a delicate tissue, that it demands and requires consideration because of its peculiar qualities is a new thought. That bone tissue must be handled gently in manipulation as well as at operation because of the influence upon the processes of repair of such trauma, is coming to be appreciated.

All these facts, together with the general perfection of the procedures of surgery should influence profoundly our appraisal of the operative method of treating fractures.

In my personal estimate of the applicability of the operative treatment of fractures, I assume that the fractures under consideration are seen immediately following injury. They are recent fractures.

The long bones to which I refer are

In the upper extremity:
- the humerus,
- the radius,
- the ulna;

In the lower extremity:
- the femur,
- the tibia,
- the fibula.

This includes fractures which enter the *shoulder, elbow,* and *wrist* joints, and fractures which enter the *hip, knee,* and *ankle* joints, as well as, of course, fractures of the *shafts* of these six long pipe bones.

By the non-operative treatment, I understand that treatment which honestly employs:

1. The suspension of the limb;
2. (Adequate) traction;
3. (Adequate) counter traction;
4. A proper hold on the limb of the traction force;
5. Manipulation;
6. Pressure;
7. Counter pressure;
8. And secures the alignment of the limb, and
9. Brings about the movement of involved or contiguous joints as early as possible.

By the *operative treatment* I understand that method which approaches the seat of fracture through an incision. The fracture is directly treated.

I would also include in the operative treatment any procedure which necessitates the making of a wound to facilitate treatment. That is, a tenotomy, the application of a pin or caliper.

I assume by the *operative* treatment

1. That the highest degree of safety to the individual will obtain;

2. That the surgeon and assistants are skilled in the use of the treatment;

3. That the surgeon possesses ability more than that needed for the ordinary care legally required;

4. That the surgeon has available necessary instruments and apparatus;

5. That the employment of that form of anaesthesia applicable to the case in hand, whether it be regional, local, spinal, or general, will be above criticism;

6. That the conduct of the operative treatment so far as the pre-operative and post-operative care are concerned is adequate.

7. I assume that the final and exact procedure chosen in the operative treatment of a given case is appropriate.

8. I assume that by this treatment the involved or contiguous joints are moved as early as is possible.

What are the conditions and the facts to be considered in formulating an opinion as to the applicability of the operative treatment thus conceived to fractures of the long bones?

1. A trial of the non-operative treatment may be made for a few days; if it is then found to be unsatisfactory, the operative treatment may be used.

2. Skeletal traction will accomplish more than skin traction and by its efficiency may take the place of the open operation.

3. The number of open operations is being materially diminished by the increasing efficient use of skeletal traction.

4. The operative treatment may secure perfect reduction.

5. Absolute fixation may be had by operation.

6. Perfect reposition is desirable, for perfect reposition means more nearly perfect function.

7. Restoration of good form to a broken bone gives a chance of nine to one in favor of good function. Allowance of bad form will give a chance of two to one against a good result. Hey-Groves. This is not an accurate estimate but is suggestive.

8. The operative treatment is a safe treatment.

9. Infection is eliminated.

10. The dangers from the sequelae of sepsis are eliminated.

11. An uninterrupted movement of joints is desirable after fracture. Absolute reduction and perfect fixation of the fracture fragments permit of the earliest movement.

12. The operative treatment will allow the maximum early movement in contiguous or involved joints. Early use of the damaged part stimulates the reparative processes.

13. Delayed union and non-union are not caused by direct treatment. I am not convinced that operation increases the likelihood of non-union.

14. Foreign non-absorbable materials are not always employed in the operative treatment.

15. Non-absorbable steel plates and screws and their equivalents are not irritating, if properly used.

16. Forcible manipulations required by the non-operative treatment may do actual harm and may be the occasion of delayed union.

17. Poorly conducted and poorly applied non-operative methods each may give poor results.

18. The results from a poorly conceived non-operative treatment should not be compared with the results from an ideal operative treatment.

19. Only similar kinds of fractures treated by well conducted methods should be compared.

20. The treatment will be modified to suit the social and industrial status of the patient.

21. Immediate, early reduction is desirable by both methods.

22. Operation is justifiable after trying non-operative treatment.

23. Operation is justifiable as an initial treatment in an increasing number of cases.

You all appreciate the difficulties attending a personal statement of this kind.

Fractures in children—the growing period.

The wonderful compensatory power of growth is depended upon to make up for the deficiencies of the non-operative treatment. How far should this "compensatory power" be permitted to influence the choice of primary treatment? It should not be permitted to influence the treatment of fractures in the lower extremity as it may be in the upper extremity.

In the upper extremity in childhood:

Certain fractures of the upper end of the humerus, high surgical neck fractures, I believe are best treated by operation and simple reposition, possibly without internal fixation. (Incision,

digital confirmation, leverage, fluoroscopic reduction.)

In fracture of the external condyle of the humerous with displacement of the small fragment, the broken condyle should be accurately replaced by operation.

Certain irreducible supracondylar fractures of the humerus should be replaced by incision and direct leverage.

A few fractures of both bones of the forearm which cannot be reduced by gentle manipulation may well be reduced by incision and leverage. Fixation by a four-screw plate may be required.

Fractures of one bone of the forearm, irreducible by manipulation, may be well reduced by incision and leverage.

In the lower extremity in childhood:

Skeletal traction will replace many operations on the femur.

Most femur fractures can be satisfactorily reduced and held by non-operative methods.

Fractures in the adult. Upper extremity. Mobility is desirable.

Operation should be done upon

Fracture of the high surgical neck of the humerus and dislocation of the head;

Fracture of the high surgical neck of the humerus and dislocation of the head;

Irreducible high surgical neck fracture;

Transverse fracture at the middle of the shaft if apposition cannot be secured.

It is so difficult to be sure whether a musculospiral paralysis associated with a fracture of the humeral shaft is due to a divided musculospiral or to a contusion of the nerve; that is, it is so difficult to distinguish between a complete and a partial paralysis, that I am inclined to treat the fracture expectantly and delay operation on the nerve. Having secured union of the bone, if the nerve is not permanently damaged, its recovery will be evident when the bone is united, and there will not have resulted undue loss of time in the repair of the nerve by the delay.

A "T" fracture into the elbow joint in an adult should be operated upon if the joint surface cannot be absolutely restored by position, and this is usually impossible.

The neck and head of the radius should be operated upon when the resulting deformity from displacement will impair motion.

Operation should be done upon both bones of the forearm, if accurate alignment cannot be immediately obtained. If the radius or the ulna is fractured with displacement of the fragments, operative replacement is indicated.

Fracture of the olecranon is best treated by the open method.

Fractures in the adult. Lower extremity.

In the lower extremity stability is desirable.

The neck of the femur: At present there should be no primary operation on a fracture through the middle of the neck of the femur. When it is proved that the fracture is not uniting, operation may be done.

Shaft of the femur: In wage-earning laborers and in young adults there are many fractures of the upper, middle, and lower third that I prefer to operate on at once.

Fractures of one or both femoral condyles should be operated upon.

Spiral fractures of both both bones of the leg are often best operated upon.

Many fractures involving the ankle joint should be operated upon.

Skeletal traction in certain oblique femoral fractures will reduce and hold the displacement.

Final opinion as to the desirability of operation versus non-operation in any fracture must rest on accumulating facts. We have today but few facts from dependable sources. We have many impressions! The best returns in adult fractures of the shaft of the femur are the more or less comparable cases from the clinics of Sherman in Pittsburgh, Campbell of Memphis, Tennessee, and Conwell in Alabama. In fracture of the femoral shaft in husky young adults all these clinics are securing splendid results: one clinic by operation, steel plate and steel screws; one clinic by anaesthesia, traction, counter traction, manipulation, reposition, and plaster of Paris splint; the other clinic by skeletal traction and plaster fixation. The treatment by operation with plate and screws seems to give a little earlier return to work than do the other methods. An average return to work of from five to six months is a satisfactory achievement following fracture of the shaft of the femur.

My contention, and this is the hopeful aspect of the matter, is that we have two very efficient methods of treatment, each requiring further use, amplification, and careful recording. As the data

accumulate, we shall get nearer and nearer to the propriety of stating at the outset, as to a certain fracture, this case should be operated upon at once; or, in this case the non-operative treatment will be satisfactory.

We may feel, I believe, that the operative treatment of fractures has come to occupy a definite and established place in general surgery. It is no longer a last resort in treatment. It is an initial method of choice. This is a very great advance in fracture treatment.

I should like to state here, and it seems to be appropriate to this subject, my conception of the qualifications of a surgeon for the operative treatment of fractures.

There are at least eight factors necessary to the qualification of a surgeon operating upon recent closed uncomplicated fractures:

1. An adequate knowledge of the patient, physically, mentally, socially, industrially.

2. An exact knowledge of the local conditions under consideration in the individual case.

3. Perfect instrumental, mechanical, and physical equipment including access to roentgen-ray apparatus.

4. An accustomed proved operative technique, delicately balanced.

5. An understanding of the sensitive nature of bone tissue, its reaction to injury, and the conditions influencing the process of repair.

6. A practical experience in the successful treatment of certain fractures by modern non-operative methods.

7. A knowledge of the various operative procedures for the immobilization of fractures.

8. An open mind in choosing the method best adapted to the case in hand.

A surgeon having the above qualifications is capable of safely treating fractures by operation.

A surgeon not having these qualifications should not employ the operative method in treating fractures.

The only underlying fundamental reason justifying the ideal operative treatment of a simple closed uncomplicated fracture is the probability of effecting the earlier return of the part to a more nearly normal function than can be secured by any other treatment.

It is established that in skilled and sane hands the operative treatment of certain recent closed fractures is a safe procedure, with an almost negligible mortality risk, with a high percentage of restored normal function in a reasonable time.

It is also established that in skilled and sane hands the non-operative treatment of certain recent closed fractures is a safe and satisfactory method of treatment, securing a high percentage of restored normal function in a reasonable time.

It should be the aim of every surgeon of traumatism treating fractures to perfect himself in both these methods.

The one method demands as much training and skill as the other.

A complete knowledge of the advantages and the technical details of each method is essential to the highest efficiency.

A general surgical training combined with a special technical mechanical training affords the most nearly ideal preparation for the treating of fractures that is possible.

The way to the accomplishment of better treatment is in three directions:

Undergraduate instruction;

Graduate instruction;

Lay propaganda.

1. A great constructive movement is on foot to secure better under-graduate medical student instruction. It is having its effect.

2. A great movement is already under way in the United States to enlighten and sympathetically help the general practitioner in his handling of fractures. This is being ideally carried out in Boston.

3. Some appropriate day there will be an illuminating lay propaganda in fractures. Such propaganda will accomplish for fracture treatment somewhat the same result that already has been so well accomplished for cancer treatment. Such lay propaganda will provide the workman with the idea of where to find the best treatment and what he may reasonably expect from the treatment instituted in his behalf.

Perhaps the day willl never come when the free choice by a workman of the physician he employs when injured will be done away with, but the corporation and the insurance companies already recognize that they are together spending in this country and in this state millions of dollars for unsatisfactory initial treatment, resulting in long disability, and in long reconstructive treatment.

Initial bad treatment is the occasion of most of the expensive reconstructive treatment.

Along with the above-mentioned movements which are really irresistible are:

1. The equally important research laboratory investigations on bone repair;

2. The focusing attention in every large and small hospital upon each fracture patient as a peculiar problem requiring skilled attention;

3. The discussion by interested surgeons, on fracture services throughout this country, of the various problems coming up in individual cases of fracture;

4. The exchange of experiences between surgeons in the friendly visiting clinics;

5. The direct and intimate association of the experienced and inexperienced men in the care of these cases, transmitting thus habits of thought and details of treatment, creating thus a climate of surgical opinion that will eventually and inevitably find its way to the remotest community.

From all these accumulated and accumulating experiences facts are being arranged in an orderly fashion, from which will eventually emerge further sane and efficient practical suggestions valuable for the general practitioner and the surgeon.

Discussion on Fractures

Dr. Hammond: Mr. President, Fellows of the Rhode Island Medical Society, and guests: We have listened to a very scientific and carefully prepared paper by an authority on the subject, and he has called to our attention the necessity of operating in certain closed fractures, which I think is being recognized throughout the world as more and more a necessity. I think Dr. Ridlon's word of caution should be also taken into consideration in this discussion. There are many factors which make up the problem. Confining ourselves to the problem of fracture itself, I think that the better trained a man is mechanically the better he appreciates the problem, the better he will be able to reduce a fracture by closed methods. The chief difficulty, as I notice in seeing many cases, elementary rules in reduction and application of splints are not followed out. The joint above and below the fracture is not always splinted right. The traction and counter-traction are not adequately done. But when all that has been done, there are still cases which need an open reduction and those should be approached, it seems to me, still with a certain amount of awe, as Dr. Scudder says. Because the bone certainly does not lend itself to surgery as do other tissues. In my experience, the open reduction of fractures results in a delayed healing more than in cases where closed methods are used. I have come to feel that in the vicinity of joints the open operation should be undertaken more readily than in the middle of the shaft, because many times these fractures in the middle of the shaft will mould themselves in place perhaps more than the X-ray will give you the idea is possible. The X-ray, it seems to me, is unwittingly leading us astray at times, and many fractures do much better than the X-ray would lead us to suppose. I have in mind fractures where the X-ray shows a very bad position in old people or in feeble individuals who would be unable to stand an open reduction and I have been surprised to see what a good functional result was obtained in those cases. But for the class of cases which Dr. Scudder has mentioned, the selective class, I feel more and more that a well thought out open reduction should be done.

Dr. Ridlon of Chicago: I have had the very great pleasure and advantage of being able to call Dr. Scudder my friend for some thirty-eight years. At that time he was a young surgeon and I thought I was a very old and very eminent orthopedic surgeon. I have remained an orthopedic surgeon and he has become a general surgeon, and your chairman has not done him entire justice in his remarks. I want to tell you that he is the leading authority in the world on fractures and that all he has told you today is true so far as Dr. Scudder himself goes. Is it true for you and me? We have all of us or most of us at times found ourselves in a position where we must treat a fracture. Now we must treat the fractures as best we can. We cannot all treat the fractures as we should—as Dr. Scudder would treat them. There are poor results from non-operative treatment of fractures and there are poor results from operative treatment of fractures. You all know that. And there are good results from the non-operative treatment of some fractures and there are good results from good operative treatment of many fractures, and I think, and I know Dr. Scudder thinks, that in his hands and in my hands and in your hands some fractures can be treated very

well by non-operative methods, and I know that all fractures can be treated well by operative methods in his hands, but I know they could not all be treated well by operative methods in my hands and I think they could not in yours. I think the whole point lies in what he said: There must be the necessary operative skill; very few have it. And there must be the necessary instruments and apparatus; they are seldom to be found at the time that the fracture is to be treated. But more than all it is necessary that the surgeon who treats the fractures by any method must know how to use his instruments and his apparatus. The general surgeon knows how to use his instruments, but very few of them are so fortunate as Dr. Scudder in their early training, and very few know how to use apparatus. Very many orthopedic surgeons know how to use apparatus, but don't know how to use the instruments successfully. Those things we must bear in mind, and you must bear in mind that if you are in a position where you must take the responsibility of treating any fracture, you must treat that fracture in the best way that you personally can treat it, and you must take into account what he has told you: the peculiarities of the individual and of his surroundings, and of his occupation, and of his family, and the neighborhood, too, because you not only have to treat the fracture, but you have to treat the man, and the man's family, and the community. All that has to be taken into consideration if you are going to get the best results for that man and for you. Now I wonder if it would be desirable, as he has told you, to develop this propaganda among the people so that they may learn where and who shall treat best the fracture which has happened. I think that the general practitioner, who must treat most of the fractures, may feel rather afraid of what may happen when this propaganda has become established. He may dread the result of such propaganda, just as he now dreads the results that we have all experienced from the X-ray propaganda. Generally the first thing that the patient wants when anything happens to him, and especially to his bones or his joints, is an X-ray, whether it is likely to do him any good or not, he wants an X-ray. And after he gets through being treated he wants another X-ray to see what has been the result of the treatment: to see whether he got his $500 worth of surgery or not. A surgeon must be a good deal of a man if he can stand up against that X-ray after the treatment has been in his opinion as good as possible and reasonably successful. So I want to say to you who are going to treat some fractures that you ought to protect yourselves in the beginning against the X-ray propaganda that has now been established, and get it well placed in the minds of your patients that you want a straight limb with as good length as can be had, and you want a useful limb, without regard to what the X-ray picture may or may not show when you have finished the treatment and you want to collect your fee. That is the thing to aim at: a straight limb and a useful limb and not an ideal X-ray picture. Sometimes you can get it and sometimes you can't. Now, it would be very desirable if we could all know what cases should be operated on and what shouldn't. Take a case like this: A surgeon, as skillful a surgeon as I know, a general surgeon, in an automobile accident sustained a transverse fracture of the femur in the upper portion of the middle third with an overlapping of somewhat more than an inch, and eight days of traction in bed with the foot of the bed tilted up and 58 pounds of weight over the pulley, and a pretty considerable relief from pain from hypodermics of morphine, didn't budge that displacement a particle. Now what is going to be done? The man was a dear friend of mine. He had two very high class general surgeons attending him, and they wanted to leave it, because he had a straight leg and only a shortening of an inch or a little more. That isn't very bad. But I was asked to come in and I said to the general surgeons, "Gentlemen, you are clean surgeons and I have confidence in you, and I am a dirty orthopedic surgeon. Now if you will do the surgery I will do the mechanics and I will take all the responsibility," and finally they consented, at the very urgent desire of the patient, and it was done. The bones were placed end to end and they were plated and the bone ultimately united. Now why should that operation be done in that case? In most cases of a fracture in that place you and I wouldn't do it. It should be done because, in my opinion, taking the facts as I have stated them, no one could know if union would take place unless the bone ends were reasonably well replaced. It might not take place because of some soft parts between those bone ends and ultimately an operation might have

to be done. I believe in that case that an operation was absolutely the thing to do. I believe my judgment, as the results have shown, was right. On the other hand, I have treated many similar cases without an operation, being satisfied with the shortening of an inch with a straight limb. So each time the final judgment must rest, as Dr. Scudder has said, upon the facts, experience and the judgment of the man who must carry the responsibility for what is done. That is the whole business. You must do what you can do best, or turn the case over to somebody that can do better; and you must do what seems to be best for that man, or that child, or that woman, wherever it may be, under the circumstances. You must put to yourselves, in every case, when you are about to treat one of these fractures, three questions: What am I trying to do; is it worth doing; and then, am I really doing it? Most people that treat fractures don't really do it.

DR. SCUDDER: I would like to say one word in closing the discussion and that is this. The injured man, the patient, the insurance company and the industrial accident board are all asking for the maximum return of function in the shortest time. Now that demand, a triple demand, is recent, but it is a tremendous demand. There is a money value placed upon the damaged individual and it has come down to dollars and cents. In New York State alone there are 60% of malpractice suits which are due to fractures alone. In an insurance company office I saw over one hundred X-ray plates of fractures of the shaft of the femur in individuals who were in the care of that insurance company following their treatment by different surgeons throughout New England, largely about Boston. Not one of those one hundred individuals had gone back to their original jobs. I saw those plates about a year ago and there have been numbers added to that group. I visited Pittsburg, saw Sherman's cases, individuals getting back to work in almost every instance on an average of five months. Now there are these two pictures. They are honest and accurate and I believe that in a community of this sort, right here in Providence, that no constructive step of any greater pecuniary value to the profession and to the community can be taken than establishing a fracture service in a hospital in this community. I don't believe that we should have specialists in the treatment of fractures, but that at the Rhode Island Hospital there should be a few individuals, upon whom the trustees of the hospital and the staff in conjunction should decide, who, in co-operation with the staff, should devote themselves to the care of these cases, should get together and handle these cases in the public ward. Let there grow up in this community an appreciation of the nicer details in the care of fractures, both by the non-operative and the operative methods.

CORRECTIVE RHINOPLASTY*

HOWARD E. BLANCHARD, M.D.
PROVIDENCE, R. I.

Facial surgery has received two great legacies from the late war; First, the vast experience gained by surgeons of different countries from thousands of combat injuries, compelling their best attention and commanding great ingenuity, and, second a remaining wealth of clinical material in Europe, for which there is no parallel in history.

The centuries elapsing from early antiquity until the outbreak of the Great War had witnessed spasmodic attempts at plastic surgery of various sorts and the amassing of much uncorrelated material and knowledge in various parts of the world. The experience gained in some fields had been frequently collected and published in many texts during the past decades. No effort to teach the basic and underlying principles, although long recognized, was ever made before last year, and it was a hopeless procedure to try and develop a technic with out knowing which particular procedure to select for a given defect.

Smith and Monk, American surgeons, operated subcutaneously to remove nasal prominences in 1895 and 1898. Joseph of Vienna reported in 1898 an original subcutaneous operation performed in 1896, by which he corrected a prominent ridge and reduced the tip in one procedure. In 1899, Goodale described a subcutaneous method for the reduction of a Roman nose. He removed a portion of the septum posteriorly to the prominence, freed the nasal bones from the maxillae and lowered the bridge. Joseph described in 1902 an operation in the triangular cartilage for potato nose; in 1904, the intranasal reduction of the bony nose and the

*Read before the Rhode Island Medical Society, June 3, 1926. Illustrated with 2 reels Animated Moving Pictures. Courtesy J. Eastman Sheehan, M.D., New York.

elevation of a pendulous septum, in 1905, an operation for shortening the nose, and in 1907, the narrowing of the tip by intra nasal excisions of narrow strips. In 1915, England and France provided special centers for plastic work and much that was original, basic and vital to success was evolved, and many improvements to existing technic perfected.

It is the purpose of the comparatively new surgery of rhinoplasty to correct deformities and malformations either by removal, alternative adjustment, or additions to the support of the soft tissues present. These abnormalities are frequently hereditary and are characterized by excessive growth of bone or cartilage or both. Hypertrophy is rare at birth and usually occurs between the ages of 12 and 25. Traumatic injuries are a factor in accidents due to our modern methods of transportation, and received by workers in industrial pursuits.

The rhinomegalic nose, as a rule is of congenital origin, and often many members of the same family are afflicted with mis-shapen noses, disproportionately large in comparison with their faces. Generally both bony and cartilaginous frame work are involved, but either one may be affected separately. The enlargement of bone may present itself as an increased dorsal prominence, with or without a hump, or width at the bony base may be greatly exaggerated. The bridge may be wide, and smoothly rounded, or it may be pebbly, ridged and having offsets due to trauma in early life. Complete fracture of the nasal bones may leave as its heritage, the unilateral oblique nose or the bilateral obliquity.

If the cartilaginous nose is involved, either in combination with the bony nose or separately we may have a very broad tip with flaring alae, or a drooping, pointed and prominent tip with flattened alae. In both of these deformities the nostrils appear very large and broad in the former condition, and long and narrow in the latter.

Abnormal length of the nose may be due to an increased lengthening of the triangular cartilage thus lowering the columella and giving the upper lip a shortened appearance, the so-called pendulous septum; or the lateral walls and alae may be correspondingly increased in length. Displacement of the triangular or lateral cartilages may likewise twist the tip far from the middle line.

Corrective rhinoplasty has now taken its proper place in surgery along with operations for strabismus and other facial defects which detract from the personal appearance of an individual. The indications for these operations therefore are economic rather than functional in some cases, although in others the patient may also be hampered by defective nasal breathing, due either to a septal deflection or a narrowing of the vestibule, through collapse of the alae. If a submucus resection of the septum is necessary, it is performed about three weeks prior to the plastic work. It is quite necessary to do a modified septum operation in these cases in order to leave as much support as possible for the work to follow. Briefly, this means that the triangular cartilage is not exsected as in the regular procedure, but after undermining the perichondrium on both sides, the cartilage is severed from the intermaxillary ridge, the vomer and the perpendicular plate of the ethmoid, leaving it attached to the nasal bones and the intercartilaginous ridge, enough bony septum is then removed to allow straightening of the bowed cartilage. It may be necessary to resort to grating of the cartilage to take out the resiliency.

If the defective breathing is caused by the small vestibule, elevation of the tip and shortening the nose will provide the required space. Too much stress cannot be laid upon the necessity of always providing enough airway.

The psychic depression, self consciousness, or supersensitiveness of these patients is a major indication for their relief. Many are the objects of ridicule, and only a few are the recipients of sympathy. They become embarrassed, sad, retiring, and often embittered toward their surroundings.

Other patients with more stable nervous systems, find themselves hindered in their professional and business activities, as well as in their personal relationships. The deformity may readily affect the choice of friends, and frequently the selection of a marriage partner.

In order to make each step of the operative procedure clear, we will take a typical case for consideration, discussing it in detail; then follow with a few brief remarks regarding another type of case and show two reels of animated movies of the reconstruction of a nose.

This patient complained of difficult nasal respiration and dripping of mucus from post. nares into

throat. Since early childhood he had been subjected to much ridicule on account of the size of his nose. After graduation from college he felt that he was unable to obtain a position on account of this misshapen organ. A submucous resection was done several weeks prior to the plastic.

The external deformity, you will observe, consisted in a gross oversized and deformed nose, affecting bony as well as cartilaginous portion. A hump of considerable proportions surmounted the bony dorsum with some irregularities of the surface. The drooping tip hung considerably below the lower borders of the alae making the dorsal profile look much like a parrot's beak. It was decided to attempt the entire correction at one operation.

Choice of Preliminary Incision

Incisions formerly used were for approach by an external route, but had the disadvantage of the possibility of a bad scar in a prominent location and are rarely used today. They were, the infraglabellar, the eyebrow, the canthal, and the horizontal across the tip of the nose. These were followed by Josephs intranasal incision, made within the vestibule, one on either side, just below and parallel to the attachment of the upper lateral cartilages to the edges of the pyriform opening. This incision obviated the drawback of an external scar and deserved a great deal of credit. It is used by some operators at the present time, but there are at least two deterrents to its use. First incision through the mucous membrane invites infection, which it is not always possible to avert, with end results not to be desired. Second, the bridge of the nose is not in line with the incision and the force applied by instruments is not in a direct line.

The columella approach is far the best, for any part of the inner nose can be reached, and with instruments passed through the incision, excision and separation can be effected from root to tip and from cheek to cheek. The columella is resistant to infection, and suturing leaves a barely discernible scar in a situation rarely visible. The operator has the choice of three incisions at this site; the columellar lift, originated by H. D. Gillies, the columellar split and the columellar retraction as perfected by Dr. Sheehan.

To proceed with the operation, the incision used was the columellar split. With a small, sharp plastic scalpel the columellar was incised through the center from tip down to but not into the deep tissues of the philtrum. The vertical edge of the septal cartilage exposed and the perichondrium elevated for a short distance on both sides of the septum.

The skin and loose tissues of the nose were now separated, first on one side, then over the dorsum and on the other side from cheek to cheek and from tip to infraglabellar region. To facilitate the separation of the periosteum an incision was then made through it from the frontal process directly over the dorsum to the end of the bony arch and then laterally on each side down to the maxilla. A special elevator was used to raise the periosteum both over and under the bony arch. The loose tissues were retracted with hair pin retractors and all irregularities polished with a coarse rasp. The hump was next attacked with a chisel of special design and the bony portion to the extent of two-thirds removed. The rest was taken in thin shavings until the nose was levelled to the normal position. The bridge of the nose had now lost its natural rotundity which was replaced by a broad flat surface, and in order to overcome this, the nasal bones on each side were fractured by means of a chisel at their attachment to the nasal process of the superior maxilla; then crushed inward by pressure of the thumbs to the median nasal line. The cartilaginous hump was then trimmed with small scissors and pared off to the normal line with an angulated knife.

Shortening the nose and elevating the tip was done by removing a wedge shaped piece of the entire thickness of the septum, including the triangular cartilage and part of the sub-septum. The base of this section was placed beneath the dorsum just above the tip, and the apex at the anterior nasal spine. The extent of the elevation is in direct proportion to the width of this section at the base and requires accurate measurement. This shortened the septum and in order to make the lateral walls correspond, it was necessary to remove similar but smaller wedges from the upper lateral cartilages, one on each side. No sutures are needed, the dressing holding the edges in place. The gap in the septum was closed with two black silk sutures passing through the triangular cartilage above and the column below and tied one on either side of the columella. The wound edges were closed with three or four muco cutaneous sutures. All bone chips and blood clots were expressed, and the columella incision closed with horsehair sutures. The vestibule packed lightly with iodoform gauze strips, adhesive strips applied to compress the tip and hold the cartilaginous nose in place, and a cop-

per saddle splint applied over the reconstructed nose.

Regarding the use of material for the support of the nose cover, in depression or loss of the nasal bridge, as in syphilitic noses and depressed fracture, many substances have been tried, but costal cartilage stands supreme and unrivalled. The injection of a hydrocarbon, as paraffin, has had its vogue, and gave good results early, but later deplorable, and has been almost entirely given up by legitimate surgeons. Some of the evil results are dissemination and diffusion into other tissues, leakage, absorption and disintegration, pressure necrosis, abscesses, retinitis, optic neuritis and sudden blindness. Obviously, not a material to place much dependence on. Much was expected of supports of gold, silver, ivory and celluloid. The two latter lend themselves readily to shaping and insertion, but living tissues seem to be intolerant of non living bodies and are forever endeavoring to expel them. To be acceptable to living tissues, the transplanted body must be capable of living. The use of these supports, even paraffin, have seemed to have given a permanent result, but the process of expulsion is only postponed. It may begin at any time preceded by abscess formation.

Other grafts as bone from the tibia or rib and even turbinates have been experimented with. Bone undergoes canalization, fibrosis occurs and general absorption follows. A fibrotic may be left as a result of degeneration and act as a support, but is not bone.

An exception to this statement should be made, and that is that bone will not absorb if both ends are placed in contact with bone, but in nasal work this is not applicable.

The ideal graft would seem to be cartilage and bone combined, as both are present in the nose, but it has been found that there is a gradual separation at the junction, with subsequent absorption and the production of a bad deformity.

Costal cartilage is the best graft at our disposal. This is a peculiar cartilage, different from any other in the body, in that it is composed of large costal cells which are nourished by lymph and not by blood as are all other cartilages in the body, the cells seeming to exert suction on the lymph stream for their life. Aural cartilage for instance is composed of yellow elastic tissue nourished by the blood stream and if used is always absorbed. Costal cartilage can be easily handled and shaped, is resistant to infection, is held in place by the formation of strong fibrous adhesions and will remain in the tunnel made for it. This cartilage never degenerates unless pressure is applied and in using it in the nose, care must be exercised to avoid this. If after insertion, beneath the skin, a white line of ischemia is apparent, the graft should be removed and made smaller.

Experience favors the use of cartilage from the patient's own body. It is removed as a block from the free ribs taking twice as much as is needed in case of an accident. One-half is shaped for the graft, and the other cached beneath the skin of the chest near the breast. The part used should be denuded of perichondrium to prevent curling. This graft assures the operator of permanence and durability.

The repair of the syphilitic nose is the most difficult operation in the realm of rhinoplasty. In the second degree type, there is a loss through ulceration, of part or whole of the septum, resulting in depression of the bridge and much scar tissue involving the nasal lining with subsequent contractures drawing the nose back into the face. The failures of the past can be traced to lack of provision of a lining for the nose. The modern operation demands not only in nasal work, but in other plastic procedures, a lining, a covering and a support. After every vestige of scar tissue has been trimmed from the mucous membrane, and a healthy surface remains, a stent of moulding compound is made within the nasal cavity of the size and shape of a normal nose. When hardened this is withdrawn, a large Thiersch graft taken from the thigh and wrapped around it, denuded surface outside, and then replaced within the nasal cavity prepared to receive it. The stent is held in place by a dental splint fastened to the front teeth. After about one week the graft will have taken and through the epitheliaziation of the denuded areas we have a new lining that will not retract.

The moulding compound is now removed and substituted by one of gutta percha. This can be taken out and cleansed daily and used for about three months as a support. The nose now has the appearance of a depressed fracture, which is remedied with a costal cartilage graft.

Discussion on Corrective Rhinoplasty

Dr. J. W. Keefe: Ladies and Gentlemen: It was my privilege about one year ago to visit this International Clinic of Plastic Surgery in Paris and I want to state that I have great regard for Dr. Blanchard for having the ambition to leave these Rhode Island shores and spend a great deal of time and energy to perfect himself in this exploratory work. Some of the cases that I saw and others that had been operated upon and presented for examination really showed a marvellous ingenuity on the part of the operator and most extraordinary results. All of us in the past have done some plastic surgery, but compared with the plastic surgery of today it was truly in its infancy. Some may think that our friend Dr. Blanchard merely witnesses these operations from the back seat, but I want to say that I came in contact with Dr. J. Eastman Sheehan, of New York, and Dr. Gillies, of London, who is said to be the greatest expert in that line today, and Dr. Blanchard, I was pleased to see, was the first assistant at the operation. So I feel that a

man who was willing to go away to perfect himself in this line should be encouraged. And I think that every man here ought to be willing to do what he can to encourage that type of work, because I feel that Dr. Blanchard was under the tuition of the ablest man in the world. They had an unusual machine that I had never seen before. They had eight spotlights which threw a very bright light on the patient's face, and with the aid of mirrors the area of the operation was transferred upward and down across through an opening in the wall, so that students could sit in a room entirely separate from the room where the operation was taking place. The pictures were thrown on the screen so you were able to follow every step of the operation while sitting in a room outside of the operating room. And it was also an advantage on the part of the color. Instead of being a black and white picture, it was really the color of the face. I want to congratulate Dr. Blanchard on his work.

LETTER TO THE EDITOR

Rhode Island Maintains Her Standards in Medical Licensure

During the past few years there have been many remarkable laws passed in a number of states governing the drugless cults. They have been written by able attorneys and have passed in legislative bodies even in fierce opposition on the part of the medical profession.

The enactment of such a law was favored recently in Rhode Island and it was endorsed by the State Medical Society. We submit herewith in part the act that was presented by the State Senator from Providence:

The passage of this act would certainly have lowered the standards of the medical profession and recognized as men of efficiency and able to treat disease those making extravagant claims.

The provisions of this bill do not end with the clothing with honor and authority the members of the long list of cults now known and giving treatment to the sick in this country, some 43 in number and for whom examining boards may be named, but it most generously provides for the tender care of any and all cultists, the names of which have not yet been determined.

How magnanimous! and this bill was brought out, advocated and strongly defended by a state medical society. It may not be necessary for a candidate to know anything of physics or biology if at some time during recent or even remote past he commenced attendance in some anti-scientific school.

Perhaps the most dangerous feature of this bill is in the fact that the Board of Education is obliged to allow any candidate passing the preliminary examination to take final examination by the cult board. This is mandatory, and the Board of Education is required to *request* and *act* upon the recommendations made by the cult boards.

It is a well known fact that some state boards of medical licensure are at the present time embarrassed by the fact that they must give all applicants an examination. It is due to this requirement that the Massachusetts Board is compelled to give examinations to men graduating from the schools of lowest grade. Some of these graduates after taking quiz courses are able to pass the test, and in only five years, 1920-1924, according to Waite, that state, with its efficient board of registration, licensed 47 graduates of St. Louis College of Physicians and Surgeons, and Colorado, facing the same embarrassment, registered 56 more during that time from the same school.

Fortunately this is not the case with the boards in most states. Because of the right to deny applicants the privilege of taking examination, graduates from poor or unknown schools of Eastern Asia and elsewhere are prevented from practicing medicine among us. It can, therefore, be seen and readily understood that this mandatory requirement that all candidates shall be allowed to take the second examination is dangerous. Any state adopting such a law as this will have a goodly number of "healing artists" who have no chance in most states.

The state of Rhode Island has maintained, in common with many others, very high standards for those whose duty it is to give treatment to the sick. After 11 years of unceasing effort on the part of the State Medcial Society, it was successful in having the duty of licensing physicians placed in 1895 with the State Board of Health. Few states since 1908 have maintained higher standards than Rhode Island, and none since 1917, when the interne year service was required.

Had this act passed, these standards so carefully considered and well enforced would have been swept away. In view of this fact, the *promotion of this bill was very generally resented.* Those responsible for it *made repeated efforts to have someone else rewrite and sponsor it,*[1] but without success. It appeared to belong properly to its authors, the knowledge of which is widespread in the medical profession and its memory will be abiding.

Authority given by Section 5 is sufficient reason for condemning the bill. Why consider for a moment that faddists, even with high school attainments, who disregard the causes of disease firmly established by scientific research, deny the existence of the germ theory and ridicule the facts accepted and proven by highly trained scientists the world over. Why should men and women holding anti-scientific notions be allowed to sign death

(Continued on page 168)

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EDITORIALS

A NON-PARTISAN ISSUE

In the coming elections this fall each voter will be asked to vote upon the question of a bond issue of $1,125,000 for State Institutions. This is a non-partisan, non-sectarian proposition and one which should appeal especially to the medical profession. There is probably no group of people going about the community, who can favorably influence public opinion upon such a humanitarian objective, as the doctor. Remember mother and daughter vote, too.

These institutions are largely presided over by medical men of the state society and represent hospitals, either in a curative or prophylactic sense. Patients are flocking to them and the management being vested in the state, your personal individual state, it is not possible to refuse admittance. You do not want your state to crowd and ill care for its sick. The world has gone ahead too fast for the term "pauper" and the word is all but lost. The state, your state, is maintaining large hospitals for its sick and the people are asked to supply funds to adequately care for them.

The State Infirmary is rapidly emerging from an almshouse, where misery was the bedfellow of misfortune—and misfortune is no respecter of persons—to a modern hospital where there should be wards as adequate in size and equipment as any hospital can afford. A hospital in every sense of the word, not an almshouse, not a poor farm, not a pauper asylum. Do not argue with persons who fear that such an institution may be made too attractive. Just remind them that every citizen of the commonwealth, regardless of his present social or financial standing, is a potential patient in this particular institution.

The State Hospital for Mental Diseases needs buildings badly. Here is an institution devoted to the mentally sick, which in itself is about three times as large as our largest hospital under private corporate management. This hospital has a large corps of medical men and is very badly in need of more housing space. Is there any reason why an institution for the sick, of which every voter is a part owner, should be compelled to have its patients sleep on the floor? Why should the state tolerate, in caring for its own, a condition which in a private institution would not be tolerated? Of course there is every reason why it should not.

It is hard to say whether Exeter School is more in need of buildings than any of the other institutions, but to say that it is acutely in need of funds is only a mild statement of facts. The work of this school from a medical viewpoint may be called largely prophylactic, but none the less medical. It is not today, and never has been given funds enough to function more than about one-third. It has and does care for a residue of hopelessly feeble minded individuals, but the other 60% of its duty has never been exercised. This other two-thirds function, from an economic standpoint more important than the first, is the temporary custody and study of the great group of morons; that class of society that is presenting the problems of illegitimacy, crime and racial degeneration. Headed as it is, by a skillful physician of the best type, this institution should have its capacity doubled at once.

The problems of these three institutions should appeal directly to the medical profession, and unless as a physician he can refute these arguments, every doctor in the state should make it a part of his professional duty in the next month to urge the passage of the proposed bond issue.

CLINICAL CONFERENCES

The Committee on Clinical Conferences for the ensuing year as sponsored by the State Medical Society, called a meeting of the physicians chosen to give the clinics. The purpose of this meeting was to explain this year's program which differs in some respects from that of last year. The committee had at hand data which was not available last year and have made good use of it in arranging the present schedule. Those clinics which were well received and appealed to physicians last year have been retained. Clinics which failed to arouse interest have been dropped. The committee feels that this feature is of importance. Another change is the omission of the winter months from the schedule. Last year, during the particularly busy time of the winter, many physicians were unable to attend the meetings. Under the new plan, conferences will be held during the fall and spring months, thus removing one of the chief obstacles to attendance. Another feature, of less importance, is that no fee will be charged for those who matriculated last year, and only a nominal one for new matriculants. The conferences were regarded sufficiently successful last year to warrant their repetition. They should be more valuable to the medical profession this year.

INFLUENZA

Foremost among the pressing medical problems of the day stands the "last of the great plagues"—influenza—a constant threat against life, liberty and the pursuit of happiness on the part of mankind. Not only is it important because of the mortality and morbidity resulting from its ravages at times when it has acquired such a high degree of virulence and contageousness as to become pandemic; but at other times when, in milder mood, it attacks with decreased vigor and causes to each victim but a few days of real illness, it can still be counted as a major problem. In "off years" so to speak—when the disease cannot be said to be even mildly epidemic—it still ranks among the main

causes of loss of time and efficiency. "But," one may ask, "what is influenza?" Text-book descriptions and the common experience of practitioners make it easy of recognition when typical, and especially when prevalent in epidemic form. Unfortunately, however, no pathognomonic sign or symptom and no diagnostic test exists. What then of the mild "grippe," so called, occurring sporadically, and clinically identical with the milder cases of epidemic "flu"? What of the gastro-intestinal and other forms often called "grippe"? Are they, or are they not, influenza?

The answer to these questions, cannot be made at present. With the etiological factor undetermined and with the diagnosis a mere clinical guess, it is no wonder that but little accurate information as to the prevalence and spread of the disease is obtainable. Sporadic "grippe"—mild though it may seem—superlatively important as it surely is—is a very will-o'-the-wisp to the investigator. It cannot be studied in large hospitals as cases are seldom admitted. In private practice it is too often neglected as a mild self-limited affair requiring no real treatment and amenable to none. "Simply a touch of grippe," we say, which is beneath the notice of the trained clinician—chiefly, it must be admitted, because he knows next to nothing about it, and can do but little for it.

But who is to attack this all important problem? The answer is clear. There is but one type of man available—the family physician. He is the man who sees the cases—the only man who can attack the problem. If practitioners generally would really take up the careful study of this much despised but all important disease; if they would make careful clinical descriptions and records of their cases with studies of the occurrence and variations of the disease in different seasons and different years the first step would be made. Better still if some group of practitioners such as, for example, the members of the Rhode Island Medical Society should by mutual agreement make a concerted attack on the disease as seen in the private practice of each, the result could not fail to be of great value. This could be done by the appointment of an influenza committee to whom the members of the society could report their cases and who could thus compile accurate data covering virtually the whole state. If this work were backed by a team of laboratory experts whose duty should be to carry on bacteriological and blood examinations on those patients whom the family practitioners would indicate as appropriate for study, the value of the whole investigation would be greatly enhanced. Properly carried out, an investigation of this nature by the members of the Medical Society would constitute a real achievement.

LETTER TO THE EDITOR

(*Continued from page 165*)

certificates or "any certificate or document which physicians are now authorized to sign"? What complications would develop if the State Registrar of Vital Statistics was compelled to accept and officially record deaths as due to pinched nerves, loose segments of the spine, or some other equally ridiculous cause. In all probability such records would prevent Rhode Island from continuing to hold its time honored place in the registration area of the United States.

The passage of this bill was urged very strongly by those who have been denied, for good and sufficient reasons, the privilege of taking examination before the State Board of Health, by many violators of the Medical Practice Act and by a few medical men. The motive of those who opposed the bill was criticized severely in a part of the public press, by propagandists who for one reason or another sought its passage, and it was by some no doubt misunderstood.

The bill aroused much interest during most of the legislative session. It passed the Senate, but opposition developed sufficiently strong to hold it in the Judiciary Committee of the House and prevent its passage.

It is gratifying to those who worked hard even under the above mentioned conditions that they were successful in the prevention of the passage of this remarkable and dangerous bill and that they have *the hearty approval*[1] of most physicians in the state.

B. U. RICHARDS, M.D.

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[1][THE RHODE ISLAND MEDICAL JOURNAL stands always ready to publish any letters that may bear upon medical affairs or policies of public welfare that interested persons choose to submit.

As a rule, we do not presume to repudiate the tenets set forth in any communication, nor does the appearance of such letters in these columns constitute an endorsement of sentiment expressed therein—this is the neutral ground of forensic liberty.

There are, however, some portions of the above letter, notably those that we have taken the liberty to italicise, that are sufficiently outstanding to inspire skepticism and indeed might invite the question as to whether the zeal of the writer has carried him into a realm beyond that of substantial exactitude.—ED.]